STATE OF ALASKA

Department of Health and Social Services

Division of Senior and Disabilities Services

Home and Community Based Waiver Services Certification Application Packet

for

Children with Complex Medical Conditions (CCMC)
People with Mental Retardation and Developmental Disabilities (MRDD)
Adults with Physical Disabilities (APD)
Older Alaskans (OA)

February 12, 2004

STATE OF ALASKA

Department of Health and Social Services
Division of Senior and Disabilities Services

Cover Sheet

Home and Community Based Waiver Services
Certification Application Packet

Children with Complex Medical Conditions (CCMC)
People with Mental Retardation and Developmental Disabilities (MRDD)
Adults with Physical Disabilities (APD)
Older Alaskans (OA)

Name of Agency: _____

Physical Address: _____

Mailing Address: _____

Telephone Number: _____

Fax Number: _____

Name of Person Completing Packet: _____

E-mail Address: _____

Return Application to:

State of Alaska
Department of Health and Social Services
Division of Senior and Disabilities
3601 C Street, Suite 310
Anchorage, AK 99503

Table of Contents

for

Home and Community Based Waiver Services Certification Application Packet

Section 1 - Overview of Home and Community Based (HCB) Waiver Services

Certification will allow you and your agency to provide waiver services and to bill Medicaid for recipients currently served under these HCB Waivers:

- Children with Complex Medical Conditions (CCMC)
- People with Mental Retardation and Developmental Disabilities (MRDD)
- Adults with Physical Disabilities (APD)
- Older Alaskans (OA)

The regulations that govern the provisions of these Home and Community Based Waivers may be found in 7 AAC 43.005 – 7 AAC 43.1990. Please read these regulations carefully to fully understand the requirements to which your agency will be held.

An agency planning to operate multiple office locations must complete an Agency Certification Application for each office location. For example, if your agency plans on providing services in Anchorage, Wasilla, Fairbanks and Juneau a separate packet must be submitted for each area.

If your agency is a private nonprofit agency or governmental agency, complete Section 3.

Complete each service section that your agency would like to provide. The Cover Sheet and Section 2 - Agency Certification Application only need to be completed once regardless of the number of services you choose to provide.

Care Coordination (CCA) Agency. Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 4 - Care Coordination Services

If certified, your agency will receive a billing number with a CMG prefix (i.e. CMG999), which is only used to bill for care coordination agency services. CMG agencies cannot bill for any other HCB services.

Habilitation Services (HS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 5 - Habilitation Services (Residential, Day, or Supported Employment Habilitation)

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Adult Day Services (ADS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 6 - Adult Day Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Residential Supported Living (RSL). Complete the following sections**:**

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 7 - Residential Supported Living

If certified, you will receive a billing number from First Health with an RL prefix (i.e. RL9999) to provide these services.

Respite Services (RS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 8 - Respite Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Intensive Active Treatment Services (IAT). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 9 - Intensive Active Treatment or Therapy Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Environmental Modification (EM). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 10 - Environmental Modifications

If certified, you will receive a billing number from First Health with an EM prefix (i.e. EM9999) to provide these services.

Chore Services (CS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 11 - Chore Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Transportation Services (TS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 12 - Transportation Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

Meal Services (MS). Complete the following sections:

- Cover Sheet
- Section 2 - Agency Certification Application
- Section 13 - Meal Services

If certified, you will receive a billing number from First Health with an HC prefix (i.e. HC9999) to provide these services.

If your agency becomes certified, you must complete a Standard Enrollment Application. This application can be downloaded from First Health Services Corporation's web site at http://alaska.fhsc.com/documents/enrollment.asp.

Section 2 - Agency Certification Application

Name of Agency: _____

Name of Owner(s), if applicable: _____

Name of Program Administrator, if different from Owner(s): _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Telephone Number: _____ Email: _____

Complete this section if your agency wants to become certified as a:

- HCB Agency
- Care Coordination Agency

If your agency would like to provide any of the following Home and Community Based (HCB) Agency Waiver services, please complete the applicable sections:

Care Coordinator

- Residential Habilitation
- Day Habilitation
- Supported Employment Habilitation
- Adult Day Services
- Residential Supported Living
- Respite Services
- Intensive Active Treatment Services
- Environmental Modifications
- Chore Services
- Transportation Services
- Meal Services

MEDICAID HOME AND COMMUNITY BASED WAIVER PROGRAMS

Please check the waiver service your agency would like to provide recipients.

Available Services	Type of Waiver Programs			
	Older Alaskans 65 + years	Adults with Physical Disabilities	Children with Complex Medical Conditions	Persons with Mental Retardation & Developmental Disabilities
Care Coordination				
Residential Habilitation	Not Available			
Day Habilitation	Not Available			
Supported Employment Habilitation	Not Available			
Adult Day Services			Not Available	Not Available
Residential Supported Living			Not Available	Not Available
Respite				
Intensive Active Treatment Services	Not Available			
Environmental Modifications				
Chore Services				
Transportation Services				
Meal Services				

AGENCY APPLICATION

REQUIRED ATTACHMENTS

Please answer the following questions, 1-8, and label attachments according to the applicable number and letter.

1. A copy of your current business license in the name of the organization you wish to have certified.

2. Worker's compensation insurance policy, comprehensive general liability insurance, commercial automotive liability insurance, and/or professional liability insurance that are applicable to the services the agency is seeking to provide. All coverage shall meet minimum levels as required by law. Attach a copy of the declarations page or quote from your insurance company.

3. Attach an organization chart of your agency or business, including job descriptions and any required training. The chart should include all paid and volunteer staff positions, lines of authority, names of all board members, and how the advisory board, if applicable, relates to the entire agency.

4. Attach articles of organization or incorporation, partnership agreement, bylaws and any other documentation showing your authority to conduct business.

5. Attach copies of your agency's emergency response and recovery plan, if applicable. The plan shall provide for a safe evacuation plan, housing and continuing services. For use in the event of flood, fire, earthquake, severe weather, prolonged loss of utilities, or other emergency (such as when scheduled providers fail to show up) that may present a threat to the health, life or safety of clients in your care.

6. Attach your agency's policies and procedures for the following:

    A. Agency's values, philosophy and mission, and human resource information.
    B. Confidentiality, including the Health Insurance Portability & Accountability Act (HIPAA) of 1996 and other federal and state requirements.
    C. All mandatory personnel licensure and training standards and schedules.
    D. Internal evaluation at least annually of each of the programs for which it is certified. The evaluation shall include:

        1) The involvement of the governing body (if incorporated), advisory board, program director, staff, consumers, families/caregivers, and other relevant agencies, organizations, or businesses.
        2) A Consumer Satisfaction Survey, which provides recipients, a regular opportunity lodge complaints about providers and/or services provided.
        3) An assessment of how well the program assisted consumers, their families and caregivers.
        4) A measurement of agency and consumer outcomes.
        5) Recommendations for improvement, corrective action of problem areas, and future program/business directions.

    E. Records retention that complies with 7 AAC 43.030.

F. Systems of fiscal and accounting processes.

G. Conflicts of interest. Should a governing board member have such a conflict, the applying agency shall show evidence of procedures that document the disclosure of the conflict and removal of the conflict, or a determination that the conflict is not material.

7. If you are currently enrolled with Medicaid or have previously been enrolled with Medicaid services in the past, please list any individual billing numbers you have been assigned. Please include any problems with compliance your agency may have had and how these problems have been addressed.

8. Consumer Contribution towards Cost of Care. By regulation, Medicaid may not be charged more for services than a person would pay privately. Provide your agency's sliding fee or contribution schedule for each service you plan provide. Describe how the schedule will be implemented and attach a copy.

GENERAL ASSURANCES

Your agency will comply with the following:

1. Civil Rights Act of 1964, (42 U.S.C. 2000d).
2. Americans with Disabilities Act, (42 U.S.C. 12101-12213).
3. Drug-Free Workplace Act of 1988 (42 U.S.C. 701-707).
4. OSHA regulations related to health, safety, sanitation and protection of employees from blood borne pathogens and contact with the Department of Labor (who must be contacted directly with any questions).
5. AS 18.220 and other federal and state laws and regulations preventing discriminatory employment practices.
6. AS 47.17.010 Child Protection and AS 47.24.010 Reports of Harm.
7. Your agency will be responsible to maintain copies of current driver's licenses, appropriate for the vehicle driven, for all individuals who transport waiver recipients.
8. Your agency must maintain copies of current CPR and First Aid cards for all employees who provide direct services.
9. Agencies shall provide proof of criminal background checks including criminal history reports and/or finger prints as required by AS 47.05.017. Your agency must conduct an initial background check as identified above for both paid and volunteer employees who have any direct contact with recipients. Your agency will update background checks once every two years after the initial check. Your agency will notify the Division of Senior and Disabilities Services (DSDS) in writing of any criminal or civil charge or conviction, including restraining orders, of any employee paid or volunteer, within 24 hours or the next business day of the incident.
10. Your agency will notify DSDS of any changes to the owner's name, project administrator's name, agency's name or agency's location, within one week of change.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to Home and Community Based Waiver services, and that all agency staff meets the qualifications identified in this certification packet.

The State of Alaska, its officers, agents and employees should be indemnified, held harmless and defended from all liability, including cost and expenses, for all actions and claims resulting from injuries or damages sustained by any person or property arising directly or indirectly as a result of any error, omission, or negligent act of the applying agency, the agency's subcontractors or anyone directly or indirectly employed by the agency in the performance of waiver services.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true and correct.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date

Section 3 - Government and Nonprofit Agency Assurance

Name of Agency: _____

It is agreed:

1. A formal governing body has full legal authority and responsibility for operation of the applying agency.

2. Board meetings are open to the public.

3. Attach a copy of your agency's IRS letter granting non-profit status, and the name, address and length of term for each member of the board of directors.

4. Tribal Health Program applicants to State waiver programs consent to be sued by the State of Alaska upon any claims arising out of the program's activities under waiver programs.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date

Section 4 - Care Coordination Services

Name of Agency: _____

If previously certified, list your Agency's CMG #: _____

Name of Program Administrator for Care Coordination: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Care Coordination services are defined in 7AAC 43.1041, please read carefully.

This section must be completed by agencies seeking certification to provide care coordination services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must meet the qualifications as described below.

CARE COORDINATION PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of experience working with families, DSDS services and service providers; including one year as a supervisor of two or more staff working in a human service field or setting characterized by responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks.

      AND

   B. Meet one of the following:

      1) Hold a BA or BS Degree in social work, psychology, rehabilitation, nursing or a closely related human services field from an accredited college or university.

         OR

      2) Hold an AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university and two additional years of full time work experience in a human service field or setting.

and two additional years of full time work experience in a human service field or setting.

OR

3) Have four additional years of full time work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting.

OR

4) Hold certification as a rural community health aide or practitioner and have a minimum of one year of full time experience related to providing home care or similar service.

2. Distinguishing Characteristics:

A. Knowledge of the medical, behavioral, habilitative and rehabilitative considerations of people.
B. Ability to establish program or service procedures, policies or guidelines and relate these to objectives.
C. Knowledge of laws, rules, regulations, precedents, terminology used in the work, requirements for HCB Waiver care coordination services, family centered services, the HCB Waiver care coordination process, knowledge of local and statewide resources available, applicable state regulations, the Individual with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA).
D. Ability to assess treatment of individuals who experience physical and/or mental disabilities.
E. Ability to organize, evaluate and present information effectively, both orally and in writing.
F. Within the last 24 months, have successfully completed and passed DSDS care coordinator training as established by DHSS.

REQUIRED ATTACHMENTS

Attach a resume, proof of education and three letters of reference for the Program Administrator. The resume, copy of degree and attached documents must substantiate that the individual meets the required level of experience, education, and distinguishing characteristics as listed above.

CARE COORDINATOR PROVIDER STANDARDS

Care Coordinators must meet the requirements listed below.

1. Education and Experience:

A. AA degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university, and one year full time of paid work experience with human service recipients and providers.

OR

B. Two years of college in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university, and one year full time paid work experience with human service recipients and providers.

OR

C. Three years of paid full time work experience with at least one year full time paid direct work experience with human services recipients and providers.

OR

D. Hold certification as a rural community health aide or practitioner and have a minimum of one full time year experience related to providing home care or similar service.

2. Distinguishing Characteristics:

A. Knowledge of the medical, behavioral, habilitative and rehabilitative considerations of people.
B. Knowledge of laws, rules, regulations, policies, procedures, precedents and terminology used in the work, requirements for HCB Waiver care coordination services, family centered services, the HCB Waiver care coordination process, knowledge of resources available, applicable state regulations, the Individual with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA).
C. Ability to assess treatment of individuals who experience physical and/or mental disabilities.
D. Ability to organize, evaluate and present information effectively, both orally and in writing, within a prescribed time frame.
E. Ability to work with professional and support staff.
F. Within the last 24 months, have successfully completed and passed DSDS care coordinator training as established by DSDS.

REQUIRED ATTACHMENTS

Attach a resume, proof of education, verification of employment, and two letters of reference for each care coordinator. Resumes, copies of degree and attached documents must substantiate that each individual meet the required level of experience, education, and distinguishing characteristics as listed above.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to care coordination services, and that all care coordinators meet the care coordination provider standards and qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

An authorized agent of the applying agency	Position
Printed Name	Date

Section 5 – Habilitation Services
Residential, Day and Supported Employment

Name of Agency: _____

Name of Program Administrator for Habilitation Services : _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Habilitation services are defined in 7 AAC 43.1045, 7AAC 43.1046 and 7 AAC 43.1047, please read carefully.

This section must be completed by agencies seeking certification to provide habilitation services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must meet the qualifications as described below.

HABILITATION PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   One year of experience working with families, DSDS services and service providers; including one year as a supervisor of two or more staff working in a human service field or setting characterized by responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks.

   AND

2. Meet one of the following:

   A. Hold a BA or BS Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university.

      OR

   B. Hold an AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university and two additional years of work experience in a human service field or setting.

OR

C. Four years of work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting.

3. Distinguishing Characteristics:

A. Knowledge of the medical, behavioral, habilitative and rehabilitative considerations of people with developmental disabilities.
B. Knowledge of laws, rules, regulations, policies, procedures, precedents and terminology used in the work.
C. Ability to assess treatment of individuals who experience physical and/or mental disabilities.
D. Ability to organize, evaluate and present information effectively, both orally and in writing.
E. Ability to supervise professional and support staff.
F. Ability to establish program or service procedures, policies or guidelines and relate these to objectives.
G. Knowledge of local and statewide resources available, applicable state regulations, Individual with Disabilities Education Act (IDEA) and Americans with Disabilities Act (ADA).

REQUIRED ATTACHMENTS

Attach a resume, proof of education and three letters of reference for the Program Administrator. The resume, copy of degree and attached documents must substantiate that the individual meets the required level of experience, education, and distinguishing characteristics as listed above. Individuals who meet the Program Administrator standards may also deliver direct habilitation services.

GENERAL ASSURANCE

The Program Administrator is required to maintain on file a resume and two letters of reference for each habilitation service provider.

HABILITATION SERVICES PROVIDER STANDARDS

All persons providing habilitation services must meet the following standards, and will be supervised by the Program Administrator for habilitation services.

1. Education and Experience:

A. Must be at least 18 years old.

AND

B. Have a high school diploma, GED, or test by the agency to assure the provider's ability to read written instructions and make appropriate chart notes; and 6 full-time months experience (paid or unpaid) providing direct patient/client care and/or training in a related field of human services (such as providing assistance to individuals and

or groups with issues such as substance abuse, aging, mental and physical disabilities or juvenile delinquency).

Assisted Living Homes: All out of home placements must be licensed homes. Attach a copy of each license and list all Assisted Living Homes licensed by the Department of Health and Social Services in the following table:

Name of Home	Address	Number of Licensed Beds	License No.

Shared Care Homes and Family Habilitation Homes: All out of home placements must be licensed homes. Attach a copy of each license and list all foster homes licensed by the Department of Health and Social Services in the following table:

Name of Home	Address	Number of Licensed Beds	License No.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to residential habilitation, day habilitation, and supported employment habilitation, and that all habilitation services providers meet the habilitation service qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

Signature of an authorized agent of the applying agency	Position
Printed Name	Date

Section 6 – Adult Day Services

Name of Agency: _____

Name of Program Administrator for Adult Day Services: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Adult Day Services are defined 7 AAC 43.1043, please read carefully.

This section must be completed by agencies seeking certification to provide Adult Day Services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must provide qualifications as stipulated below.

ADULT DAY SERVICES PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. Must be at least 21 years of age.

      AND

   B. Meet one of the following:

      1) Hold a BA or BS Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university.

         OR

      2) Hold an AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university and two additional years of work experience in a human service field or setting.

         OR

      3) Four years of work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting.

      AND

   C. Have skills in administration, planning, coordination, supervision, counseling, and the delivery of adult day services or other services to the recipients.

C. Have skills in administration, planning, coordination, supervision, counseling, and the delivery of adult day services or other services to the recipients.

REQUIRED ATTACHMENTS

1. Job descriptions of all staff that will be administering and providing adult day services. These should include job qualifications and duties.
2. A resume and two references for the Program Administrator and Activity Coordinator.
3. An organization chart and a brochure and/or a client handbook.
4. If used, attach a copy of your agency's sliding fee scale for clients. Indicate the amount privately paying clients are charged for full cost of care per day, per half-day, or per unit.
5. The agencies written procedures for handling emergencies. This procedure must be posted in the facility and in program vehicles.
6. Adult Day Program's hours of operation, including a policy for closing during inclement weather and designated holidays.
7. Plans for individual and group activities suitable for the needs and abilities of recipients and designate who is involved in planning activities.
8. Plan for providing transportation for recipients for any planned recreational outings.
9. Program size, maximum number of participants, and staff to participant ratio.
10. Entire floor plan with square footage of each room with bathrooms labeled.
11. The agency's policy and procedure for administration of medications.

GENERAL ASSURANCES

1. The Program Administrator is required to maintain on file a resume and two letters of reference for each employee.
2. All meals will be provided by a certified DSDS provider.
3. Agree to comply with the Program Standards which were adopted by the Alaska Commission on Aging on February 20, 2003.

ADULT DAY SERVICES PROVIDER STANDARDS

All persons providing adult day services must meet the following standards. The Program Administrator will supervise adult day service providers.

1. Education and Experience:

   A. Adult day service workers must be at least 18 years old.

      AND

   B. Have adequate skills, education, and experience to serve the population in a manner consistent with the philosophy of the adult day program.

      AND

   C. The ability to follow directions and keep records of tasks performed.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to adult day care standards, and that all adult day care providers meet the adult day services provider qualifications referenced and/or identified in this certification packet and regulations.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true and correct.

An authorized agent of the applying agency | Position

Printed Name | Date

Section 7 – Residential Supported Living

Name of Agency: _____

Name of Program Administrator for Residential Supported Living: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Residential Supported Living (RSL) services are defined in 7 AAC 43.1044 and 7 AAC 43.1058, please read carefully.

To receive certification by Division of Senior and Disabilities Services and to enroll with Medicaid as a RSL provider under Medicaid HCB Waiver Programs, agencies must be currently licensed by the State of Alaska as an assisted living home.

1. Attach a copy of the assisted living home license for each location you plan to certify. Label as 1A.

2. Attach a copy of your facilities inspection conducted by the Department of Health and Social Services licensing staff. Please list any deficiencies you must correct if any and indicate when corrective action(s) will be taken and the completion date(s). Attach a separate sheet, label as 2A.

3. If your assisted living facility license ever been suspended, describe the reason(s) for suspension and the actions that were taken for reinstatement. Attach and label as 3A.

4. Attach a copy of your resident/recipient admission policy, house rules, and resident contract, etc. Label as 4A.

5. If your residence admission policy does not include all of the care services your agency/business provides please attach those guidelines to this application. Label as 5A.

6. Indicate the charges you will bill a “private pay” recipient if using a sliding fee scale. You may indicate that all private pay recipients will pay the same amount or more as a HCB Waiver recipient. Please indicate if this is a comprehensive rate or are there charges for services such as for a private room. Attach and label as 6A.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements of a RSL provider and will meet the qualifications identified in this certification packet and licensing requirements of the department.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true and correct.

_____

Authorized agent of the applying agency Position

_____

Printed Name Date

Section 8 - Respite Services

Name of Agency: _____

Name of Program Administrator for Respite: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Telephone Number: _____ Email: _____

Respite Services are defined in 7 AAC 43.1049, please read carefully.

This section must be completed by agencies seeking certification to provide respite services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must meet the qualifications as described below.

RESPITE PROGRAM ADMINISTRATOR STANDARDS

The Program Administrator for this service must meet the following requirements.

1. Education and Experience:

   A. One year of experience working with families and service providers; including one year as a supervisor of two or more staff working in a human service field or setting characterized by responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks;

      AND

   B. Meet one of the following:

      1) Hold a BA or BS Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university.

         OR

      2) Hold an AA Degree in psychology, social work, rehabilitation, nursing or a closely related human services field from an accredited college or university and two additional years of work experience in a human service field or setting.

         OR

3) Four additional years of work experience in psychology, social work, rehabilitation, nursing or a closely related human services field or setting.

2. Distinguishing Characteristics:

   A. Knowledge of the medical, behavioral, habilitative and rehabilitative considerations.
   B. Knowledge of policies and procedures of the Waiver Agency and terminology used in the work.
   C. Ability to assess treatment of individuals who experience physical and/or mental disabilities.
   D. Ability to organize, evaluate and present information effectively, both orally and in writing.
   E. Ability to supervise professional and support staff.
   F. Ability to establish program or service procedures, policies or guidelines and relate these to objectives.

REQUIRED ATTACHMENTS

1. Job descriptions of all staff administering and providing respite services. These should include job qualifications and duties.
2. A resume, proof of education and three letters of reference for the Program Administrator. The resume, copy of degree and supporting documentation must substantiate that the individual meets the required level of experience, education, and distinguishing characteristics listed above.
3. Describe your agency's previous experience in providing respite or similar services.
4. Describe how your agency will involve family members in the selection and training of a respite worker.
5. Describe the training provided to respite workers to address emergency situations.

GENERAL ASSURANCE

The Program Administrator is required to maintain on file a resume and two letters of reference for each respite provider.

RESPITE PROVIDER STANDARDS

All respite providers must meet the following qualifications.

1. Must be at least 18 years old.

   AND

2. Have a high school diploma, GED, or is tested by the provider to assure employee can read written instructions and make appropriate chart notes.

   AND

3. Possess the ability to communicate with the recipient to whom s/he is assigned, and with his or her supervisor.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to respite services, and that all respite providers meet the respite provider qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date

Section 9 - Intensive Active Treatment Services

Name of Agency: _____

Name of Program Administrator for Intensive Active Treatment: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Intensive Active Treatment (IAT) Services are defined in 7AAC 43.1048, please read carefully.

Health care providers already enrolled with regular Medicaid as physicians and nurses do not need to request HCB waiver certification, nor should their services be included on the HCB Waiver portion of the Plan of Care. The services of providers already enrolled in Medicaid should be acknowledged on the Plan of Care, billed directly to Medicaid and paid directly to the provider.

INTENSIVE ACTIVE TREATMENT PROVIDER STANDARDS

Intensive Active Treatment providers must meet the following requirements.

1. IAT service workers are at least 18 years old.

   AND

2. Hold current state licensure or certification (i.e. substance or alcohol abuse treatment) to provide treatment defined in an approved Plan of Care.

   AND

3. One year full-time work experience in the treatment area that the individual will provide (i.e. one year of substance abuse treatment).

REQUIRED ATTACHMENTS

1. Applicable license or certification as specified in item two above.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to intensive active treatment services, and that all intensive active treatment/therapy providers meet the intensive active treatment/therapy qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

An authorized agent of the applying agency	Position
Printed Name	Date

Section 10 - Agency Based Environmental Modifications

Name of Agency: _____

Name of person who completed this section: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Agency Based Environmental Modifications are defined in 7 AAC 43.1054, please read carefully.

AGENCY BASED ENVIRONMENTAL MODIFICATION PROVIDER STANDARDS

1. Obtain the assistance of a licensed electrician, mechanical contractor, or plumber, with the appropriate Certificate of Fitness issued under AS 18.62.010, to perform all work subject to the Uniform Code adopted by the State, for electrical or plumbing installation or modification per AS 18.60.580, AS 18.60.705.

2. Perform all work in a timely manner, adhering to the estimated start and completion dates as stated on the cost estimate sheet.

GENERAL ASSURANCES

1. No work will be performed for which a cease and desist order has been issued by the Department of Labor.
2. Upon loss of contractor's license or claim against/or loss of bond, your agency will notify DSDS in writing within 24 hours or the next business day.
3. There will be no material substitutions using lower quality materials contrary to the cost estimate.
4. All equipment installation must follow the manufacturer's recommendation for installation and/or all applicable code requirements and guidelines.

REQUIRED ATTACHMENTS

1. Current Alaska General Contractor's License.
2. Current contractor's insurance and bonding eligibility.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to be in full compliance with all terms of the certification requirements and fulfill all of the requirements pertaining to Home and Community Based Waiver services. And that all agency staff meets the qualifications identified in this certification packet and in regulations.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true and correct.

Failure to comply with the above assurances, constitutes an automatic breach of this agreement and enrollment as a Medicaid provider, making us automatically ineligible to receive Medicaid reimbursements and could subject the enrollment as a Medicaid provider to be terminated. Furthermore, any reimbursement for work performed while not in compliance with this agreement could be subject to recoupment by the DSDS.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date

Section 11 - Chore Services

Name of Agency: _____

Name of Program Administrator for Chore: _____

Community(s) to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Chore Services are defined in 7AAC 43.1042, please read carefully.

This section must be completed by agencies seeking certification to provide chore services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must meet the qualifications as described below.

CHORE SERVICE PROGRAM ADMINISTRATOR STANDARDS

1. Education and Experience:

    A. One year of experience working with families and service providers; including one year as a supervisor of two or more staff working in a human service field or setting characterized by responsibility for planning, development, management or operation of programs and service delivery, fiscal management, needs assessment, program evaluation and similar tasks.

    AND

2. Distinguishing Characteristics:

    A. Knowledge of policies and procedures of the Waiver Agency and terminology used in the work.
    B. Ability to organize, evaluate and present information effectively, both orally and in writing.
    C. Ability to supervise and support staff.
    D. Ability to establish program or service procedures, policies or guidelines and relate these to objectives.

REQUIRED ATTACHMENTS

1. Job descriptions of all staff administering and providing chore services.

2. A resume, proof of education and three letters of reference for the Program Administrator. The resume, copy of degree and attached documents must substantiate that the individual meets the required level of experience, education, and distinguishing characteristics listed above.
3. Describe your agency's previous experience in providing chore or similar services.
4. Describe how your agency will involve family members in the selection and training of a chore worker.
5. Describe the training provided to chore workers to address emergency situations.

GENERAL ASSURANCES

The Program Administrator is required to maintain on file a resume and two letters of reference for each employee

CHORE SERVICE PROVIDER STANDARDS

All chore service providers must meet the following qualifications.

1. Must be at least 18 years old.

   AND

2. Have a high school diploma, GED, or is tested by the provider to assure employee can read written instructions and make appropriate chart notes.

   AND

3. Possess the ability to communicate with the recipient to whom s/he is assigned, and with his or her supervisor.

AGENCY AGREEMENT

Your signature below indicates your agency has agreed to fulfill all of the requirements pertaining to chore services, and that all chore services providers meet the chore services qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

An authorized agent of the applying agency	Position
Printed Name	Date

Section 12 - Transportation Services

Name of Agency: _____

Name of Program Administrator for Transportation: _____

Community to be served: _____

Telephone Number: _____ Fax Number: _____

Cellular Number: _____ Email: _____

Transportation Services are defined in 7AAC 43.1052, please read carefully.

This section must be completed by agencies seeking certification to provide transportation services under the Home and Community Based Waiver Programs. In addition to the requirements listed in Section 2, service providers must meet the qualifications as described below.

The Program Administrator for transportation services must maintain copies of each employee's current driver's license appropriate for vehicle(s) operated and their driving record (completed within the past 12 months).

TRANSPORTATION SERVICE PROGRAM ADMINISTRATOR STANDARDS

1. Transportation providers must be 18 years old.

   AND

2. Have sufficient education and experience in performing transportation services required by individuals on the HCB Waivers or meet with requirements under DSDS NTS grant.

   AND

3. Any vehicle that is in a business/company name is considered a commercial vehicle for registration fee purposes. As leased vehicles are owned by a business/company, they are automatically considered commercial vehicles for purposes of biennial fees. This includes vehicles that would normally be considered passenger vehicles. There are different insurance rate requirements for commercial vehicle operation, AS 19.10.300. 5.

   OR

4. If your agency is receiving grant funding for an established transportation program through the Division of Senior and Disabilities Services, Nutrition, Transportation and Support Services Program and agency staff are providing the transportation services provide a copy of the notice of grant award.

REQUIRED ATTACHMENTS

1. Current driver's license appropriate for the vehicle used.
2. Current vehicle registration.
3. Current proof of Insurance.

AGENCY AGREEMENT

Your signature indicates your agency has agreed to fulfill all of the requirements pertaining to transportation services, and that all transportation providers meet the transportation services qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date

Section 13 - Meal Services
(Congregate or Home Delivered)

Name of Agency: _____

Name of Program Administrator for Meals: _____

Meal Preparation Location(s): _____

Check type(s) of meal service you will provide: _____ Congregate _____ Home Delivered

Telephone Number: _____ Fax Number: _____

Cellular Telephone Number: _____ Email: _____

Meal Services are defined in 7 AAC 43.1053, please read carefully.

This section must be completed by agencies seeking certification to provide meals under the Medicaid Home and Community Based Waiver Programs. In addition to the requirements in Section 2, service providers must meet the following qualifications.

MEAL SERVICE PROVIDER STANDARDS

1. Meal providers must be 18 years old.

   AND

2. Have sufficient education and experience in performing meals services required by individuals on the HCB Waivers or meet with requirements under DSDS NTS grant.

   OR

3. If your agency is receiving grant funding for an established meal program through the Division of Senior and Disabilities Services, Nutrition, Transportation and Support Services Program and agency staff are providing the meal services, or through an established Department of Education School Lunch Program, provide a copy of the notice of grant award.

GENERAL ASSURANCES

1. Your agency complies with the State of Alaska, Department of Environmental Conservation (DEC), Food Service Regulations, 18 AAC 31.

2. If your agency uses subsistence foods, they meet standards of quality, sanitation and safety, as set forth in DEC regulations 18 AAC 31 and the DEC Field Directive regarding the use of subsistence foods.

REQUIRED ATTACHMENTS

1. Job descriptions of all staff that will be administering and providing meal services. These should include job titles, qualifications and duties.
2. Last local inspection or a State of Alaska, Department of Environmental Conservation Food Service Establishment report of your facility.
3. A description of the methods of delivery that will ensure preparation safety, sanitation and delivery.
4. Proof of successful completion of Food Safety System training approved by the Department of Environmental Conservation, Division of Environmental Health, Food Safety and Sanitation Program's Active Managerial Control.
5. A sample menu(s) that have been reviewed and signed by a registered dietician/nutritionist. Cycle menus are used and are reviewed by a qualified nutritionist or dietitian to ensure balanced meals that meet the Recommended Daily Dietary Allowances.

AGENCY AGREEMENT

Your signature indicates your HCB Waiver Agency has agreed to fulfill all of the requirements pertaining to meal services, and that all meal service providers meet the meal service qualifications identified in this certification packet.

Failure to maintain and provide upon request to the DSDS accurate and up-to-date certification records, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient, can be cause for revoking certification and potentially lead to Medicaid sanctions, including repayment of Medicaid payments for services, as referenced in 7 AAC 43.950.

As an authorized agent of the applying agency, I affirm that I have read and will adhere to conditions and requirements under 7 AAC 43.005 – 7 AAC 43.1990 inclusive, that all agency staff meet the required levels of experience, education and training to provide HCB services, and that the information in this application is true.

_____

An authorized agent of the applying agency Position

_____

Printed Name Date